Fidelity and influencing factors in the Systemic Practice Model of children's social care in Finland

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Highlights

• An adaptation of the RSW model was implemented nationwide in Finland.

• There was high variability in fidelity both across sites and in the teams within them.

• Despite the implementation challenges, social workers widely accepted the model.

• The vague model description impeded the uptake of systemic practice in social work.

• The model could be adopted in new settings with adequate implementation support.

Abstract

Given that multiple countries have recently adopted social work practice models in children's services, it is striking that only a few studies have systematically analysed both the level of fidelity and potential implementation barriers and facilitators. The aim of this study is to provide an in-depth analysis of how and why the Reclaiming Social Work (RSW) model works in different settings. The study context was the implementation in Finland of an adaptation of the model, the Systemic Practice Model (SPM). This mixed-methods study evaluates 1) fidelity to the SPM and 2) the possible influencing factors. The results reveal high variability in the extent of fidelity in 23 implementation sites, and even among individual teams within the same site. A lack of clarity concerning systemic social work practice, insufficient training, and inadequate resources and leadership hindered the implementation, whereas coaching and positive experiences of the SPM were facilitating factors. In particular, the involvement of a clinician qualified in systemic family therapy was crucial in embedding the new approach. The relationship between the level of fidelity and the influencing factors worked both ways (e.g., low coverage was associated with a decrease in participant responsiveness, and vice versa). Given the complexity of children's social care as an implementation environment, careful preparation and ongoing support are crucial in the implementation of practice models.

1 Introduction

In recent years, multiple countries have adopted social work practice models (or practice frameworks) to improve outcomes for children and families (Gillingham, 2018). Practice models are embedded in a particular theory and practice approach, which guide all stages and aspects of social work (Baginsky et al., 2020; Barbee et al., 2011). Despite their popularity, a number of evaluations related to such models describe challenges in their implementation (e.g., Antle et al., 2012; Laird et al., 2018). Ultimately, failure in this regard compromises the model's effectiveness (Durlak & DuPre, 2008). The present study analyses the initial nation-wide implementation of the Systemic Practice Model (SPM) in Finland. The SPM is an adaptation of the Reclaiming Social Work (RSW) model (Goodman & Trowler, 2012), developed in an English child and family social work agency. The aim of the model is to deliver systemic social work practice in children's services.

The purpose of this study is to assess implementation fidelity (i.e., the extent to which the intervention is delivered as intended) and to formulate hypotheses concerning the possible influencing factors, which could be tested and refined in future evaluations. The undertaking of a comprehensive fidelity assessment gives researchers and practitioners a better understanding of how and why the model works in different contexts and the extent to which its outcomes can be improved (Carroll et al., 2007). A detailed implementation analysis is essential particularly when transporting interventions from one cultural context to another (Sundell et al., 2014).

The present study addresses several gaps in the existing research. First, it represents the first attempt to evaluate the fidelity of the RSW model, including its adaptations outside England. Second, it complements previous implementation studies on practice models in combining fidelity assessment and the analysis of influencing factors (Carroll et al., 2007). The objectives are:

1. to describe the level of fidelity of the SPM by measuring the details of its content, dose (in other words frequency and duration) and coverage;
2. to identify possible implementation barriers and facilitators based on participant experiences.

1.1 Fidelity and influencing factors

Although multiple terms are used in the literature, in the context of evaluation research fidelity usually refers to the extent to which implementers adhere to the programme as it was designed by the developers (Carroll et al., 2007). It is necessary to measure fidelity because failure to deliver the core components as intended ultimately influences the intervention outcomes (Durlak & DuPre, 2008). Consequently, fidelity is considered one of the key outcomes of implementation (Proctor et al., 2010). However, Toomey et al. (2020) point out that fidelity is increasingly viewed as a more multi-faceted concept, which focuses not only on the delivery of a programme but also on interrelationships between domains such as delivery and receipt (see e.g., Bellg et al., 2004). In essence, merely assessing fidelity does not provide information on the factors that influenced the implementation outcomes. Mindful of this, we chose the Conceptual Framework for Implementation Fidelity (CFIF) (Carroll et al., 2007) as an evaluation framework because it facilitates the joint analysis of fidelity and influencing factors. It also incorporates the different measurement areas and acknowledges their relationships. In general, frameworks broaden current understanding of fidelity, guide its assessment and enhancement, and support the structuring and standardising of research, all of which enhance comparability and the synthesising of findings (Toomey et al., 2020).

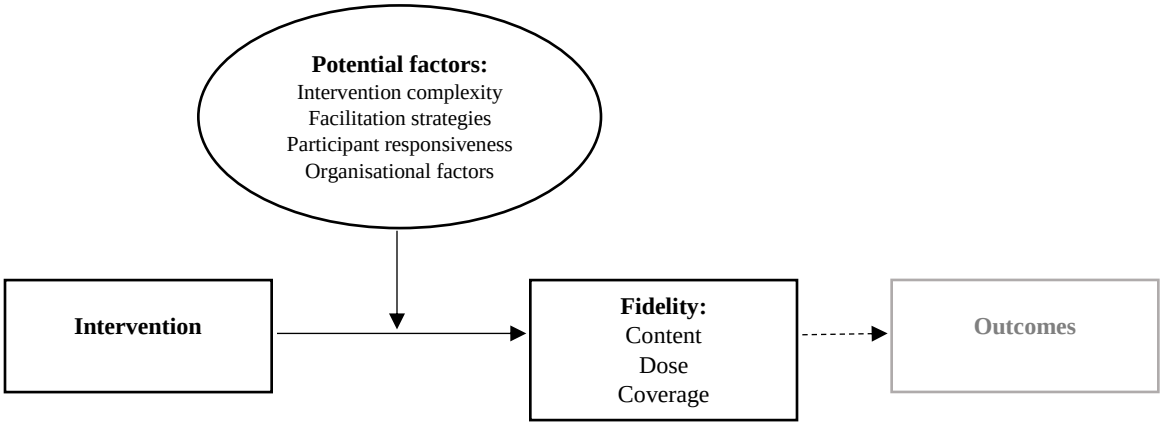
According to Carroll et al., (2007), fidelity (or adherence) may be measured in terms of the content, coverage (or reach), frequency and duration of the intervention: the last two measures could be included in the concept of dose. Evaluators should assess the extent to which the content of the intervention, in other words the ‘active ingredients’, have been administered to the participants as often and for as long as intended. The degree to which the intended content, dose and coverage have been delivered is the degree of implementation fidelity achieved for that model.

Various influencing factors may facilitate or impede the level of fidelity, and they may influence each other (facilitation strategies could enhance the quality of the delivery, for example). The factors (or moderators) included in the CFIF include intervention complexity (a description of the intervention and its real nature), facilitation strategies (e.g., training, manuals), the quality of delivery (the appropriateness of the process) and participant responsiveness (engagement with the model). Responsiveness refers both to the service users and to those responsible for delivering the model (Carroll et al., 2007). The modified version used in this

study (Hasson, 2010) has two additional factors: context (e.g., the surrounding social systems as well as historical and concurrent events) and recruitment (procedures used to attract potential intervention participants). Our assessment of the influencing factors focuses on intervention complexity, facilitation strategies, participant responsiveness and organisational factors. The focus is on a provider context (von Thiele Schwarz et al., 2019), in this case social work teams. Because this evaluation was of the initial implementation of the SPM, and it relied on survey and interview data, we excluded the assessment of the quality of delivery. We also excluded the assessment of client recruitment because that factor is not applicable in the context of a statutory child protection service, given its involuntary characteristics. To avoid conceptual confusion, we use the term 'influencing factor' as well as 'barriers and facilitators' instead of 'moderators' in this article. Figure 1 below illustrates the application of the CFIF in this study.

Figure 1.

The assessment of fidelity and the influencing factors in the present study in accordance with the modified CFIF (Hasson, 2010, originally from Carroll et al., 2007)



Although the balance between fidelity and adaptation is continuously addressed in the literature, many studies take 'one or the other position' without explicitly considering the level of 'appropriate' adaptation (von Thiele Schwarz et al., 2019; Miller et al., 2020; Toomey et al., 2020). The authors of these studies therefore recommend addressing the issue of fidelity and adaptation throughout the process, as well as exploring coexistence potential by explicating the core components of the intervention. Even the core components may be changed or removed in some instances, but such actions should be carefully planned and measured so as to avoid

unintentional deviation (Stirman et al., 2013; Miller et al., 2020). Accordingly, we define the core components of interest in Section 2.2, and in terms of measures in Section 2.5.

In sum, evaluation of an implementation may prevent the drawing of potentially false conclusions about its effectiveness in that it provides insights into the process and the factors that influence the outcomes (Carroll et al., 2007). Moreover, careful documentation of the process enhances the generalisability of the findings to other sites (Crea et al., 2009).

1.2 The Systemic Practice Model (SPM) and its implementation

The SPM is a Finnish adaptation of the RSW model, which incorporates systemic family therapy into child and family social work. The RSW has not been manualised, but the general ideas, values and theories underpinning it have been published by its co-founders (Goodman & Trowler, 2012). The overarching idea is to form small, multi-disciplinary units including a social worker, a systemically trained family therapist, a consultant social worker leading the team and a unit coordinator. Team members receive training in systemic thinking and methodology, and in the use of tools with families as well as within the weekly team meetings that serve as the main mechanism for case supervision. To our knowledge, thus far the RSW model has been implemented only in its country of origin.

The SPM was disseminated and implemented by the Finnish Institute of Health and Welfare (THL) in 2017-2018, funded by the Ministry of Social Affairs and Health. To support agencies in its implementation, THL published a paper describing the general idea of the model (Lahtinen et al., 2017), and organised national training of trainers (ToT). It also organised three national workshops for child protection managers, the aim being to inform them about systemic practice and its implementation.

1.3 Implementation evaluations of social work practice models

To date there have been few studies assessing the fidelity of practice models such as Signs of Safety (SoS) from Australia and Solution-Based Casework (SBC) from the United States. Researchers have identified high variability in the implementation of these models (Antle et al., 2012; Sheehan et al., 2018). Antle et al. (2012), for example, demonstrated with regard to SBC that a higher level of fidelity was associated with better case outcomes, whereas Sheehan et al. (2018) concluded in their review that there was limited evidence of whether SoS has been

implemented well. Roberts et al. (2019) recently developed a fidelity-measurement tool for SoS, but to date there are no published systematic fidelity assessments.

A number of evaluations have identified barriers and facilitators in the implementation of practice models (Lambert et al., 2016; Pipkin et al., 2013; Sanclimenti et al., 2017; Sheehan et al., 2018). The most substantial influencing factors include a supportive leadership and organisational climate, high-quality training and coaching, as well as alignment with other organisational systems and initiatives. Some studies also list high staff turnover as a significant implementation barrier (Roberts et al., 2019; Sheehan et al., 2018). Despite the positive experiences of professionals and service users with the models (Antle et al., 2012; Sheehan et al., 2018), the evaluations highlight the complexities involved in their implementation, particularly in large public systems. Above all, previous research emphasises the need to engage the whole organisation, including its senior leaders, in the change effort to support implementation (Lambert et al., 2016; Pipkin et al., 2013; Sanclimenti et al., 2017; Sheehan et al., 2018).

1.4 Evaluations of the Reclaiming Social Work (RSW) model

It has been concluded from previous evaluations of the RSW model that its implementation increases the quality of children's services compared to service as usual. According to a mixed-method evaluation carried out in the original children's services site in Hackney (Cross et al., 2010), social workers in new RSW units were more satisfied with the work environment, the social work processes and work-related wellbeing than practitioners who were not using the model. In addition, the number of looked-after children had decreased by 30 per cent during the period 2005/2006 - 2008/2009. Forrester et al. (2013) compared the RSW units in Hackney with two other sites in their realist-informed mixed-method evaluation. They concluded that practitioners in the RSW units spent more time with families, made high-quality assessments, demonstrated high levels of direct practice skills, and provided more intensive help for families. On the basis of their evaluation in other sites implementing the RSW, in turn, Bostock et al. (2019) quantified and paired observations of supervision (n =14) with observations of direct practice (n =18) and found a statistically significant association between the quality of case supervision and the quality of social work practice with families. However, it should be noted that the overall evidence base concerning the effectiveness of the RSW and other practice models is still limited (Isokuortti et al., 2020).

According to both mixed-methods evaluation focusing on five sites (Bostock et al., 2017) and qualitative evaluations focusing on one site (Laird et al., 2017; 2018), there is extensive variability in how a team structure is adopted, team meetings are run, and systemic practice is implemented. Bostock et al. (2019) report a variation in the quality of systemic case supervision in observed team meetings (n =14) from non-systemic to 'encouraging' and 'fully systemic'. Laird et al. (2017; 2018) and Morris et al. (2017), in turn, found limited changes in social work practice in one agency that did not implement any structural changes.

Bostock et al. (2017) concluded that a systemically trained consultant social worker as a leader, systemic case discussion, clinician input and dedicated administrative support are vital in ensuring good systemic practice. Bostock et al. (2019) further stress the importance of having a clinician present to ensure the full incorporation of systemic concepts and practice in the supervision. Laird et al. (2018) emphasise the need to implement the whole model as intended given that a reduction in the amount of training for managers prevented the establishment of shared values and the changing of procedures and practice. Laird et al. (2017; 2018) further note that the caseloads of social workers should to be aligned with systemic practice to allow enough time for them to learn the new approach. Both Bostock et al. (2017) and Laird et al. (2018) found that recruitment challenges and staff turnover impeded implementation, and they stress the importance of supportive leadership and the engagement of the whole system in the change. Notwithstanding the challenges, the practitioners were satisfied with the RSW model, which they believed had improved their practice through its collaborative, reflexive and purposeful approach (Bostock et al., 2017). In addition, most families had positive perceptions of children's social care based on systemic practice (Bostock et al., 2017; Morris et al., 2017).

The initial evaluation of the model in Finland reflects the English implementation experiences. The Finnish case shows that high caseloads in particular impeded the uptake of systemic practice, although the social workers had generally positive perceptions of the model itself (Aaltio & Isokuortti, 2019). Nevertheless, there is still a need for a joint analysis of the interrelationship between the fidelity of the model and the possible factors that influence it, which is the focus of this study.

2 Materials and methods

2.1 Study design

A mixed-methods approach was used in the present study to allow an in-depth analysis of implementation fidelity and the participants' perceptions of the potential factors that influence it. We adopted a concurrent transformative design, which incorporates simultaneous qualitative and quantitative data collection and analysis followed by mutual interpretation of the findings based on a specific theoretical perspective (Creswell & Plano Clark, 2008). The primary data we used in our investigation of fidelity were quantitative, which we complemented with qualitative data. Our analysis of the influencing factors, in turn, was based on qualitative data complemented with quantitative data. Complementing the quantitative fidelity assessment with the qualitative analysis gave us a more detailed view on the use of systemic social work practice. Furthermore, comparing the qualitative interview findings with the survey results allowed us to compare the participants' perceptions on influencing factors in the three sites with data from a larger sample, as well as to preliminarily test some of these assumptions with the quantitative data.

Our study was further influenced by realist evaluation (Pawson & Tilley, 1997), which is a theory-driven form of evaluation that purports to formulate and refine theories explaining why a programme does or does not work. Realist evaluation is rooted in the realist philosophy of science. The point is that change is seen as a result of underlying mechanisms that are not always observable, thus the purpose is to identify these mechanisms by theorising and testing hypotheses based on these theories with empirical data. It is also understood that the functioning of mechanisms depends on the context. Hence, the aim is to understand what works, for whom, and under which circumstances.

Our aim is to formulate hypotheses about possible relationships between context and fidelity based on our mixed-methods data. We acknowledge that the model may work in some settings but not in others, hence our intention is to analyse how different factors, especially the context, may influence implementation (see also von Thiele Schwarz et al., 2019 on fidelity and context). The context referred to in realist evaluation includes the material, the social, the psychological, the organisational, the economic and the technical (Greenhalgh et al., 2017). Consequently, team-level facilitation strategies and participant responsiveness as listed in the CFIF are different 'types of context', whereas intervention complexity refers to the characteristics of the model. To avoid conceptual confusion, we use the term "organisational factors" for what Hasson (2010)

refers to as “context”. As a result of our analysis, we have formulated hypotheses of how different factors, especially the context, influence implementation. The study was conducted in parallel with an outcome evaluation.

2.2 Operationalising the core components of the SPM

The original RSW model comprises a whole system reform, which involves structural changes (e.g., forming systemic units) and adapting the 7S framework to achieve effective practice. The approach is based on shared values, such as collaboration and respectful work, and skills derived from systemic family therapy and social learning theory (Goodman & Trowler, 2012). Forrester et al. (2013) outlined six features that distinguished RSW units in Hackney from conventional social work teams: (1) shared work, (2) in-depth case discussion, (3) a shared systemic approach, (4) skills development, (5) special roles and (6) low caseloads (pp. 88-102).

The Finnish adaptation was inspired by all the above-mentioned features, but the set of skills and theories differed. The most significant differences from the original model are the following: a larger team size, a focus on team-level change instead of training and coaching both practitioners and managers, as well as introducing new methods (such as inviting families to team meetings) and tools (such as the ‘collaborative helping map’ or ‘three houses’) from outside the RSW curriculum. In addition, ideas and their operationalisation evolved during the initial implementation. As an illustration, some implementers began to invite families to the team meetings during the implementation period, whereas others wished to restrict the meetings to professional groups to support learning and reflection. Consequently, the implementers did not share a mutual understanding about which of the ideas and SPM components were more important than others, or how to put them into practice (Aaltio & Isokuortti, 2019). Following the initial evaluation the researchers suggested to the national stakeholders that a series of workshops be held aimed at formulating a first SPM programme theory: this is currently under review.

On the basis of the findings from the initial evaluation and the stakeholder discussions, we identified the following three core components of SPM: (1) a team structure comprising a consultant social worker, between one and three social workers, a clinician (i.e., a qualified family therapist) and a coordinator (in total a maximum of eight members); (2) the holding of weekly reflective team meetings; and (3) systemic social work practice. First, the clinician helps

the social workers with their systemic thinking and the use of family-therapy techniques, and the coordinator assists them with administrative tasks thereby giving them time for intensive casework. The consultant social worker provides practice leadership, whereas social workers take responsibility for the cases. Second, the purpose of the weekly team meetings is to reflect and find multiple perspectives on family cases by applying systemic thinking and similar techniques. The intention is that these systemic supervision sessions will help social workers to reflect on their cases and to plan interventions to support families. Third, to enable them to work with families in a systemic way, social workers are trained to follow a systemic approach and to apply the relevant techniques in their practice. The identified key techniques were genograms, formulating systemic hypotheses and circular questions, of which only first two were part of the initial training. Adopting a systemic approach entails frequent face-to-face work with families to exploit the full potential of these techniques. In conclusion, our fidelity assessment is based on these components (see Section 2.5).

2.3 Procedure

Ethical approval was granted by the National Institute of Health and Welfare Research Ethics Committee (2017–09). The research data was collected between five and twelve months after the commencement of the implementation at the site. The lead author designed the interview protocols, on which the second author gave comments, and conducted interviews with all social workers in June-September 2018 as well as with sixteen service users in July-November 2018. A research assistant conducted four interviews with service users at site three (two children and two parents), following the lead author's guidance and a shared interview protocol (see Section 2.5.2.2). All the participants were given information sheets, and they signed a consent form concerning their participation and the audio recording. The service users were offered a cinema voucher as an incentive, and the social workers participated in the interviews during their work hours. The interviews with the social workers were conducted in team-based focus groups, whereas the service users were interviewed individually. All the interviews were conducted face-to-face apart from one: a parent at site two was interviewed by phone. The social worker focus-group meetings lasted between 87 and 130 minutes, and individual interviews with service users between 26 and 63 minutes. After the interviews, the lead author discussed the initial findings with the second author based on the notes. The lead author was responsible for the qualitative

analyses, including assessing the adoption of systemic practice based on the interviews (see Section 2.5.1.6). The interviews were recorded and transcribed verbatim.

The second author collected administrative data in February 2018 as part of the national evaluation conducted by the Finnish Institute for Health and Welfare (THL) in 2017-2019. This data was gathered from managers via administrative forms in a national workshop supporting the implementation. The forms included questions regarding the team structure and the resources of SPM teams, as well as the implementation schedule in each site. If information was missing, the supervisors were asked to complete the forms via email. In addition, the second author designed a survey (see Section 2.5), which was refined based on reflective discussions with the steering group of the national evaluation and the lead author. The survey was conducted in September-October 2018. The invitation and the link to the survey, and two follow-up reminders, were sent via email. The email addresses of the social workers were collected from managers after permission to conduct the research given at each site. All the participants gave their informed consent prior to their inclusion in the study.

2.4 Sampling and participants

The model was implemented between the autumn of 2017 and the summer of 2018 among 52 teams in 31 municipal children's service sites located in 14 counties around Finland. All these sites were asked to participate in the quantitative research and to give permission for survey data to be collected from practitioners. Permission was received from 27 implementation sites, of which one decided to withdraw due to implementation difficulties and three failed to deliver contact details for sending the survey. The four sites that did not grant permission to conduct the research informed the researcher that they had postponed the implementation, or could not name a responsible person to be contacted regarding the research permission and the participants. The 23 sites that eventually participated in the research covered 74 per cent of all known sites. Within these sites, the SPM was implemented among 39 teams focusing primarily on child protection and covering 75 per cent of all SPM teams. The survey was sent to all social workers in these teams (response rate 44%, $n = 56$), whereas administrative data was collected at a national workshop and through emails from managers.

Qualitative interviews were conducted with social workers and service users in three purposefully selected sites, in which the outcome data (see Section 2.1) was also gathered. All the sites were large (<100 000 habitants) enough to include multiple child protection teams to

allow comparison. However, they varied geographically: site one is situated in Southern, site two in Eastern and site three in Central Finland. These sites were also convenient choices given their willingness to allow more extensive data collection. Nine child protection teams in these sites implemented the SPM. All the social workers in these teams (N = 44) were invited to be interviewed, of whom 32 agreed (participation rate 73%). Table 1 presents the characteristics of the social-worker participants.

Table 1.

The characteristics of the social workers participating in the interviews and the survey

Characteristics	**Social worker interviews (N = 32)**	**Social worker survey (N = 56)**
	M (SD)	*M (SD)*
Team size (i.e., a number of team members)	7.9 (1.1)	8.0 (1.5)
Caseload	Range 22-53	40.3 (15.6)
The length of the implementation period at the time of the data collection, months	5.6 (0.9)	7.7 (1.8)
	n (%)	*n* (%)
Model still in use at the time of the data collection Yes No Unsure	 22 (69) 3 (9) 7 (22)	 43 (83) 3 (6) 6 (12)
Has received SPM training Yes No	 28 (88) 4 (12)	 53 (95) 3 (5)
Has received post-training coaching Yes No Unsure	 15 (47) 17 (53) 0 (0)	 38 (69) 11 (20) 6 (11)
Working in a team with a structure that fulfils the fidelity criteria Yes No	 0 (0) 32 (100)	 15 (27) 41 (73)

Service users (n = 20) were selected with the help of the social workers, because not all families served by the team had experience of systemic practice (see Section 3.1). The participants included six 12-17-year-old children (five girls and one boy) and 14 parents (12 mothers and two fathers). All of them had been involved in child protection prior to the implementation. Given that we did not aim to collect data from all the families involved in the teams we did not calculate the participation rate.

2.5 Measures

The fidelity measures were based on the authors' operationalisation of the core components of SPM (see Section 2.2). Table 2 gives an overview of the measures used to indicate the level of fidelity (see also Section 2.5.1) and questions concerning influencing factors, which were analysed from the interview (social workers and service users) and survey (social workers) data (see Section 2.5.2).

2.5.1 Fidelity

The fidelity thresholds were constructed as follows. First, we defined the content of the high-fidelity category for each measure. Given that the evaluation focused on the initial stage, our threshold for high fidelity was set below a perfect performance but on a level that clearly indicates the delivery of the model (see also Section 1.1). Next, we defined the category of medium fidelity such that it included signs of promising efforts to deliver the model but excluded cases that indicated only slight changes in teams or practices. The low-fidelity category included cases that indicated minor or no changes. Given the subjective nature of this process, the researchers formulated several versions of the fidelity thresholds, which were jointly discussed and refined based on the preliminary analyses.

Table 2.

An overview of the uses of quantitative and qualitative data for the evaluation of fidelity and the influencing factors, based on the modified CFIF (Hasson, 2010)

FIDELITY			
Core component	**Indicator**	**Fidelity thresholds**	**Data source**
Team structure	Content Adoption of the team structure -Consultant SW -Max. 3 SWs -Coordinator -Clinician -Max. 8 team members	High: All structural changes completed Medium: Involving the clinician and coordinator, team size too large Low: Involving the clinician, no coordinator, team size too large	Administrative data
	Dose The amount of a clinician's work in teams, hours per week	High: min. 10% Medium: 1-9% Low: No input	Administrative data
	Dose The amount of a coordinator's work in teams, hours per week	High: 50-100% Medium: 21-49% Low: 0-20%	Administrative data
Team meetings	Coverage The number of cases discussed in a team meeting	High: min. 4 cases Medium: 2-3 cases Low: max. 1 case per SW per implementation month	SW survey
Systemic practice	Content Use of key techniques	High: Use of both techniques with multiple service users Medium: Use of one technique with multiple service users Low: Use of techniques in a single case or none	SW survey
	Content Adoption of systemic thinking and techniques	High: 7-10 Medium: 4-6 Low: 0-3 grade in scaling the systemic practice	SW interviews
	Dose Intensive casework	The proportion of cases in which the SW can work intensively High: 80-100% Medium: 21-79% Low: 0-20%	SW survey
INFLUENCING FACTORS			
Factor	**Question**		**Data source**
Intervention complexity	How complex is the model?		SW interviews and surveys
Facilitation strategies	What strategies (e.g., manuals, guidelines, training and coaching) were used to support the implementation and how were they perceived by the social workers?		SW interviews and surveys
Participant responsiveness	How did the social workers and families engage with the model (e.g., satisfaction, enthusiasm, perception of outcomes of the intervention)?		SW interviews and surveys Service user interviews
Organisational factors	What organisational-level factors affected the implementation?		SW interviews and surveys

Note. SW, social worker.

2.5.1.1 Adoption of the team structure

The managers completing the administrative form were asked to report the number and type of practitioners and other professionals working in each SPM team. An ideal SPM team would have the following characteristics: 1) a consultant social worker, 2) a maximum of three social workers 3) a clinician, 4) a coordinator and 5) a maximum of eight team members. The data was recoded by counting how many of these characteristics a team fulfilled each team being given a score from zero to five. Each team was further categorised in the fidelity categories as follows: high-fidelity implementation applied to teams fulfilling all five criteria; medium-fidelity implementation applied to cases in which the team had a clinician and a coordinator, but had not effected other changes; and if the team had a clinician but did not fulfil any other criteria, the fidelity level was low.

2.5.1.2 The extent of the clinician's work in teams

The managers were asked for what percentage of their weekly working hours the clinician(s) were available to the team. The intention was for each team at least to have a clinician present in the weekly meetings, which would mean a contribution of 10 per cent of weekly working hours. Hence, 10 per cent constitutes the high-fidelity threshold, 1-9 per cent medium-fidelity, and no input low-fidelity.

2.5.1.3 The extent of the coordinator's work in teams

The managers were asked for what percentage of their weekly working hours the coordinator(s) were available to the team. The coordinator was expected to take notes in the weekly meetings and to help social workers with other administrative tasks. Hence, 50-100 per cent of weekly working hours would meet the high-fidelity criteria, 21-49 per cent medium-fidelity and 0-20 per cent low-fidelity.

2.5.1.4 The number of cases discussed in the team meetings

The social workers completing the survey were asked how many cases in total they had discussed with their SPM team in the weekly meeting during the implementation period. This number was divided by the number of months the implementation had lasted (excluding one summer month), according to the respondent. High fidelity required covering a minimum of four cases per social worker per implementation month, medium fidelity 2-3 cases and low fidelity one case or less.

2.5.1.5 The use of key techniques

The social workers were asked if they had used genograms and hypotheses during the implementation. There were four response categories: “Not at all”, “With one service user”, “With more than one service user” and “I can’t say / I do not recognise this technique”. The fidelity threshold for this indicator was considered high if the respondent had used both key techniques with multiple service users, medium if he or she had used either genograms or hypotheses with multiple service users, and low if he or she had used these tools with one service user, or not with any.

2.5.1.6 The adoption of systemic thinking and the relevant techniques

Depending on how the interviewees described their practice, the teams were graded on a scale ranging from zero to 10 (0 = no change, 10 = major change) based on a detailed scale (see Table 3). The scale was constructed in collaboration with the second author in line with the social workers’ descriptions in the interviews concerning the adoption of systemic thinking and techniques. The interview protocol is described in Section 2.5.2.1. From each transcript, the lead author assessed the extent to which the participants described their a) systemic thinking using related terms and ideas, b) their use of systemic thinking in practice with families, and c) their use of systemic techniques in practice. All the teams were further categorised in low-, medium- or high-fidelity groups (low: grades 0-3, medium: 4-6, high: 7-10). The interviewees in three of the teams showed considerable variation in their adoption level and were therefore assessed individually. Thus, their team grading was based on the median of the individual grades. Other more unified teams were given a joint grade without an individual analysis.

Table 3.

Qualitative assessment of the adoption of systemic thinking and techniques.

GRADE	DESCRIPTION
Low 0-3: No or little change in adopting systemic thinking in social work practice	**The interviewees:**
0	Do not describe any change in thinking and say that they have not changed their practice
1	Mention some systemic principles, but do not describe their relationship with social work practice/view the connection as distant
2	Mention some systemic principles, but have not reflected on how the principles relate to their own practice
3	Mention some systemic principles and have reflected on how the of principles relate to their own practice
Medium 4-6: Signs of systemic thinking and practising the techniques	
4	Mention some systemic principles and techniques as well as planning to use the techniques in practice
5	Briefly describe a change in thinking towards a systemic approach and mention obtaining ideas from the systemic team meeting for their own practice
6	Briefly describe a change in thinking and have purposefully attempted to apply systemic ideas or techniques in practice (e.g., used a timeline or a question that the clinician proposed)
High 7-10: Evidence of the application of systemic thinking and techniques in practice	
7	Describe a change in thinking with a few practical examples as well as indicating the use of systemic techniques or the active application of systemic ideas in practice
8	Describe a change in thinking with some practical examples as well as indicating the practising of systemic thinking and key systemic techniques (e.g., have used a genogram)
9	Elucidate a change in thinking with several practice examples and systemic terms, as well as indicating the use of the techniques several times in practice, with good results
10	Elucidate a change in thinking with several practical examples and systemic terms, and indicate the continuous use of the techniques in practice, with good results

2.5.1.7 Intensive case work

The social workers were asked about the number of cases since the beginning of the implementation in which they had been able to work more intensively than previously. This number was then divided by the total number of cases with which the social worker was dealing at the time. The resulting measure was used to indicate the dose of systemic practice. This new variable was categorised in three fidelity groups, as follows: high fidelity, including social

workers who reported working more intensively with 80 per cent of their cases or more; medium fidelity, including respondents who had been working with between 21 and 79 per cent; and low fidelity, referring to those working with a maximum of 20 per cent of their cases.

2.5.2 Influencing factors

2.5.2.1 Focus groups with social workers

The social workers were asked semi-structured questions concerning their views on the SPM and their implementation experiences. The interview protocol covered the following themes: 1) Describing the model at the site, 2) Experiences of the model and its implementation, 3) Experiences of implementation support (e.g., training), 4) The work environment (e.g., well-being) and 5) Perceptions of the potential use of the model in the future. An example of an interview question addressing fidelity was: "Could you describe the systemic model you have implemented this year?". After they had done so the interviewees were shown the components of the model on paper and were asked probing questions about the delivery of each one. Examples of questions addressing influencing factors included: "What has gone well in the implementation of the model?"; "What has been challenging?"; "What would you do differently in the implementation?"; "What do you think of the model at the moment?"; "On a scale from one to five, how motivated are you to use the model?"; "How clear does the model seem to you?"; and "What factors have supported you in the implementation?" Further probing questions were asked about the practitioners' responses, including their perceptions of the training.

2.5.2.2 Individual interviews with service users

The children and parents were asked semi-structured questions addressing their current perceptions of child protection practice, whether practitioners had used systemic techniques with them, and their views on these techniques. The interview protocol covered the following themes: 1) Background (e.g., involvement with child protection services), 2) Meetings with social workers, 3) Experiences of systemic social work practice, 4) Participation and communication with social workers and 4) Satisfaction with and expectations of child protection services. Questions addressed to service users focusing on perceptions of practice included: "Could you describe your meetings with your social worker?" and "On a scale from one to five, how satisfied are you with the child protection services at the moment?" Questions focusing on

systemic techniques included: “Have social workers drawn a genogram with you to discuss your family members, and if so, what did you think about it?”

2.5.2.3 SPM clarity

Eight items were used to measure how the social workers responding to the survey perceived the clarity of the SPM. The main question was “In adopting the new approach in your practice, how clear do you find the following aspects of the systemic model?” The specific aspects were: “The composition of the team and the different roles”; “The structure of the weekly team meetings”; “The methods used in the weekly team meetings”; “The basics of systemic thinking and family therapy”; “Formulating hypotheses”; “Drawing a genogram”; “Dealing specific child protection issues systemically” and “Assessing safety and risk in systemic practice”. The social workers gave their responses on a five-point scale ranging from one, clear enough to five, not clear at all. A sum variable indicating *overall SPM clarity* was calculated, ranging from eight to 40 (M = 19.48, SD = 6.40).

2.5.2.4 Satisfaction with the training

The following seven items were used to measure how satisfied the social workers were with the training: “The training prepared me to implement the systemic model”; “The training gave me a clear understanding of how to implement the systemic model in daily practice”; “The training was concrete enough”; “The training material was useful”; “The length of the training was suitable”; “There was enough material on how to put the systemic model into practice”; and “The training was well delivered”. The responses were given on a five-point Likert scale ranging from one, Strongly agree, to five, Strongly Disagree. Single items were recoded by combining categories 1 and 2, and 4 and 5 to measure the proportion of respondents agreeing or disagreeing with the statements. In addition, a sum variable indicating *overall satisfaction with the training* was calculated, ranging from seven to 35 (M = 21.78, SD = 7.69).

2.5.2.5 Experiences of the weekly team meetings

How the respondents experienced the team meetings was measured on two items - “The collective reflection during the weekly team meetings has helped me to do my work better”; and “I have received the necessary support from the team meetings” – rated on a five-point Likert

scale ranging from one, Strongly agree, to 5 Strongly Disagree. A sum variable was calculated ranging from two to 10 (M = 4.16, SD= 2.18).

2.5.2.6 Experiences of support received from a clinician

Clinician support was also measured on two items - "The clinician has helped me to understand the family from a new perspective" and "The clinician has helped me to plan how to proceed with the family in a new way" – rated on a five-point Likert scale ranging from one, Strongly agree, to five, Strongly Disagree. A sum variable was calculated ranging from two to 10 (M = 4.02, SD = 2.01).

2.5.2.7 Satisfaction with the SPM and its implementation

W*illingness to continue using the SPM* was measured on one item, "I want our team to continue using the systemic model", as was *willingness to recommend the SPM to colleagues,* "I could recommend the systemic model to my colleagues", and the burden caused by the implementation, "The implementation of the systemic model has been an additional burden". In each case the responses were given on a five-point Likert scale ranging from one, Strongly agree, to five, Strongly Disagree.

2.5.2.8 Caseload

The respondents were asked to report the total number of child-protection cases they were currently dealing with.

2.6 Data analysis

2.6.1 Quantitative analysis

The quantitative data was organised and recoded (see Section 2.5), and the percentage frequencies were calculated. The Spearman correlation coefficient was calculated to examine the correlation between the variables, and a one-way analysis of variance (ANOVA) was used to examine the differences between the means of fidelity groups. The SPSS Statistics 24 package was used for the quantitative analyses.

2.6.2 Qualitative analysis

The lead author applied theoretical thematic analysis, which involves identifying the themes in a 'top-down' fashion to explore a theoretical framework (Braun & Clarke, 2013, p. 178), namely

the CFIF in this article. The analysis proceeded in the following six steps: (1) reading and familiarisation, (2) coding the dataset, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes and (6) writing and finalising the analysis (Braun & Clarke, 2013). The ATLAS.ti program was used to code the transcripts.

Having done an initial reading of the interviews (phase 1), the lead author coded them all, guided by the CFIF (phase 2). The entire data set was coded, but with a particular focus on the influencing factors of interest (Table 2): whether they appeared in the data and what the interviewees were discussing concerning them. Given that the central organising concepts, i.e., themes (Braun & Clarke, 2013, 224), were generated from the CFIF (intervention complexity, facilitation strategies, participant responsiveness and organisational factors), the search for patterns concentrated on the related sub-themes (phase 3). All the codes added under the themes were collated and analysed to identify patterns. Visual mapping of themes and ATLAS.ti code reports were used in the identification process. The themes and sub-themes were reviewed multiple times to achieve coherence, and were discussed with the second author (phase 4). A keyword search was used to identify potentially overlooked parts. When all the themes had been defined (phase 5), all the citations connected to them were categorised as either barriers or facilitators (see Table 4). Finally, the relationships between the different themes were explored and the thematic map was finalised (phase 6). The analysis was deepened by means of data quantification and an analysis of code co-occurrence. The quantification focused on themes (i.e., influencing factors) and their categorisation as either barriers or facilitators (e.g., how many citations under the theme ‘intervention complexity’ were described as barriers or facilitators). The number of times a code was mentioned was counted. The unit of analysis was the entire sentence or paragraph as spoken by the interviewee. All occurrences were counted. The lead author translated the citations selected for this article into English (reported within quotation marks).

Table 4.

The themes generated through the qualitative analysis with sub-themes, example citations and associated implementation categories based on the participants' perceptions

Theme derived from the CFIF (i.e., influencing factor)	**Sub-theme**	**Example citation**	**The example citation categorised as a barrier or a facilitator**
Intervention complexity	A lack of clarity in the content of systemic practice	"Although we had the training, what is that systemic practice in the end, and how does it differs from what we already do?"	Barrier
	Varying learning experiences	"This jumping into the unknown [using new skills with families] was sometimes unpleasant."	Barrier
Facilitation strategies	Training	"It was very good, that training."	Facilitator
	Coaching	"Our clinician has actually taught us to use those circular questions."	Facilitator
Participant responsiveness	SW: positive experiences of the SPM	"Our clinician often provides the kinds of new perspectives that can really support your own practice."	Facilitator
	SW: negative experiences of the SPM	"If [the meeting] is all that jibber-jabber, then no, neither I nor my clients benefit from it."	Barrier
	Family experiences of the SPM	"Discussing our family situation in the meeting triggers thoughts. The professionals took different family members' roles and then shared what they thought about the situation. I think those were quite good thoughts."	Facilitator
Organisational factors	Caseloads	"SW4: Well in this context I think it's very difficult to implement. I: And by context you mean? SW4: Well, maybe time, caseloads."	Barrier
	Leaders' commitment to change	"At the same time [leaders] want us to do our work better. But then nothing… it eats me that the agency washes its hands completely of the resource situation."	Barrier
	Staff turnover	"People come and go. That is one of the biggest changes."	Barrier

Note. SW: social worker; I, interviewer.

2.6.3 Mixed-methods analysis

Having conducted separate quantitative and qualitative analyses, we identified commonalities and discrepancies between our findings to complete the results in the interpretation phase (Creswell & Plano Clark, 2008). We also analysed the participants' perceptions on implementation barriers and facilitators, and formulated hypotheses concerning their potential linkages to the fidelity of the model. We tested the key hypotheses with the quantitative data.

3 Results

3.1 Fidelity

We observed considerable discrepancies in the different areas of fidelity measurement. Table 5 summarises the results pertaining to fidelity.

Table 5.

A summary of the results concerning fidelity

Areas to measure	**Indicator**	**The level of fidelity achieved**
Details of content Was each of the core components implemented as intended?	Adoption of the team structure -Consultant SW -Max. 3 SWs -Coordinator -Clinician -Max. 8 members	From all teams 45% scored high 32% medium 24% low adherence to the content
	Use of key systemic techniques with service users	From all SWs 36% scored high 34% medium 30% low adherence to the content
	Adoption of systemic thinking and techniques	From nine local teams 3 scored high 4 medium 2 low adherence to the content
Dose (frequency/duration) Were the core components implemented as often and for as long as intended?	The amount of a clinician's work in teams, hours per week	From all teams, 76% scored high 22% medium 3% low dose in the clinician's contribution
	The amount of a coordinator's work in teams, hours per week	From all teams, 21% scored high 32% medium 47% low dose in the coordinator's contribution
	Intensive casework	From all SWs, 2% scored high 20% medium 79% low dose of intensive casework
Coverage What proportion of the target group participated in the intervention?	The number of cases discussed in a team meeting during the intervention period	From all SWs, 5% scored high 9% medium 86% low in coverage.

3.1.1 Team structure

All the teams involved included a clinician and a consultant social worker (see Table 6). However, we learned from the interviews that some teams were without a clinician after only a few months, and some received very little support from the consultant social worker. The

clinicians' contributions to the team in terms of working hours varied from three to 110 per cent (several clinicians in one team) of working hours per week (M = 18%), whereas the variation in the coordinators' work was between three and 100 per cent (M = 26%). One fourth of the teams did not have a coordinator. When we looked at the indicators related to the systemic team as a whole we found that only six per cent of the teams met all three fidelity criteria (i.e., the right structure and high contributions from both the clinician and the coordinator), whereas 39 per cent achieved high scores on two indicators, and 41 per cent on only one indicator. In addition, 14 per cent of the teams did not achieve a high score for fidelity on any of these indicators.

Table 6.

Results related to the structural content of the team

Adoption of the team structure: involvement of professionals	**Per centage (%) of all teams participating in the study (n = 38)**
Consultant SW	100%
Clinician	100%
Coordinator	76%
Max. 3 social workers	62%
Max. 8 members in a team	84%
Teams fulfilling all team characteristics listed in the table	45%

3.1.2 Team meetings

The vast majority (86%) of the social workers achieved low scores in terms of the number of cases the social workers presented to the team in the weekly meeting during the implementation period: the responses varied from one case to 35 per social worker (M = 7). Proportional to the implementation months (one summer month excluded), this meant that the social workers, on average, brought only one case per month to the case discussion. At the time of the follow-up survey the intervention period had lasted from between two to 12 months (M = 8), depending on the team. We observed in the qualitative sample that the implementation was hampered in three teams before the follow-up data collection: one had no clinician, and two involved the clinician approximately only once a month.

3.1.3 Systemic practice

Only one third of the social workers scored highly on the use of key systemic techniques. The majority (79%) achieved low scores in terms of the frequency of family meetings, and one in four (25%) had not been able to increase the intensity with any of their cases. None of the social workers scored highly, whereas 27 per cent achieved low scores on both of these indicators. Our qualitative analysis of the adoption among social workers of systemic thinking and techniques revealed considerable variation (range 3-9) between the teams involved (see Table 7). Interestingly, we detected variability both between teams in the same sites as well among individuals in the same team.

Table 7.

Qualitative results concerning the adoption of systemic thinking and techniques

IMPLEMENTATION SITE AND TEAM	*M*	EXAMPLE CITATION
Site 1		
Team 1	9	SW5: "It is like their family system, and the purpose is that we professionals will withdraw at some point." SW3: "When we drew a genogram, we were really surprised that the father actually started to talk about those things [family history and relationships]. And we progressed with their case in a whole new way."
Team 2	6	SW2: "I also think that not-knowing assigns responsibility to the families that they will resolve [their own problems]." SW4: "I don't actually know what that systemic thinking is."
Team 3	8	SW1: "I think that drawing a genogram has had the most significant impact on my thinking." SW4: "I don't think that I would have achieved such good results as I did together with the team." SW3: "I don't think my thinking has changed at all [laughs]. If we think about what we have done, I think we have done systemic practice all the time."
Team 4	4	SW1:"The same for me, I have added those [systemic] ideas to the child-protection plan and have gone through them on a general level… [- -] but I haven't changed my actual practice at all."
Site 2		
Team	4	"SW1: I think perhaps we have adopted systemic thinking somehow. But maybe we could use those techniques more. I: What techniques have you used so far? SW2: Well I don't know if I have used any of those techniques we went through in the training. SW1: Probably mostly the same [laughs] and familiar ones, cards and games."
Site 3		
Team 1	6	SW2: "This implementation has activated me to try some techniques, for example, I had never used that reflective discussion in a family meeting before."
Team 2	3	"I: [D]o you feel that you work differently than before [the implementation]? All SWs: No."
Team 3	3	SW1: "It is very difficult to identify any changes in my own practice. I just noticed that I don't know these [systemic] techniques."
Team 4	9	SW2: "We used [the genogram], and met both parents separately many times." SW1: "Since the implementation we have started to think more not only about the families' systems, but also that we are part of those systems."

3.2 Influencing factors

Among the citations in the interviews related to the influencing factors (N = 877), 37 per cent describe facilitators and 63 per cent barriers, thereby highlighting implementation-related challenges. Depending on the circumstances, the influencing factors might either impede or encourage the implementation (e.g., some social workers perceived the training as helpful, others disagreed). As anticipated, the factors also involved various interconnections.

3.2.1 Intervention complexity

Intervention complexity was coded as a barrier in 90 per cent of the interview citations in which it is mentioned (N = 138). We identified two themes: a lack of clarity in the content of systemic practice and varying learning experiences of the new approach. Although the team structure and the purpose of the team meetings were generally clear to the social workers, a number of them found the content of systemic practice in real-world settings, including the use of systemic techniques with families, somewhat confusing. As one of them stated, she had "no clear idea what should concretely happen in family meetings" when applying systemic practice. In comparison with the results of our survey, it seems that systemic practice was somewhat clear in theory. Systemic thinking and family therapeutic orientation were clear enough to 71 per cent of the respondents, and with regard to the techniques, 52 per cent were clear about formulating hypotheses, and genograms were clear to 75 per cent.

Several interviewees further remarked that the new way of working required plenty of learning. Some, for example, found participating in reflective case discussions in the team meetings more demanding than in the previous solution-oriented team discussions. Those who described applying systemic thinking and techniques in their practice demonstrated in-depth professional learning and related positive stress. Engaging with systemic practice had forced them to step out of their "comfort zone", thus changing their perceptions of social work practice and acquiring new communication skills. On the other hand, a few of them described feelings of frustration and incompetence when they tried to use difficult techniques in their work practices. Forging closer relationships and discussing childhood traumas also made some of them doubt their own practical skills.

3.2.2 Facilitation strategies

Two themes related to strategies intended to facilitate implementation included the team-based training and coaching in systemic practice. Facilitation strategies were described as facilitative in only 31 per cent of the citations in which they were mentioned (N = 128).

The training in particular divided opinions. Some social workers described it as "good" and "necessary", providing essential information about the model, whereas others said it was "superficial" and lacking in "structure" and "consistency", leaving them confused about the systemic practice in place prior to the implementation. All the interviewed teams had expected the training to offer concrete suggestions and guidance on techniques for engaging in systemic social work, an "understanding of what systemic practice actually is". Moreover, some social workers felt that the trainers belittled their current ways of working, thereby fuelling conflict between the new approach and service as usual. Some interviewees would have preferred the training to have lasted longer than six days, and to have continued for longer than a few months. Consistently, our quantitative findings reveal that, on the national level, 40 per cent of social workers were satisfied with their training, whereas 43 per cent were not. Likewise, only a quarter of the survey respondents perceived the training as concrete enough, whereas a third said it had given them a clear idea of how to follow systemic practice in their work. Some of the interviewees suggested that the lack of clarity might be connected to the poor quality of the ToT and the trainers' inexperience in systemic social work. Indeed, 29 per cent of the trainers felt that they were not properly equipped to instruct the teams in the use of genograms or the art of hypothesising (Aaltio & Isokuortti, 2019).

On the general level, training-related challenges could explain the lack of clarity concerning the content of systemic practice described in Section 3.2.1. The results of the Spearman correlation indicate a significant positive association between overall satisfaction with training and overall SPM clarity ($r_s(48) = .36$, $p = .010$). The quantitative findings also reveal that, in the view of 46 per cent of the respondents, there was not enough supporting material to enable them to incorporate systemic practice into their routines.

The coaching provided by the trainers was not considered particularly useful in many of the interviewed teams. However, the view in four of them was that the clinician or other colleague trained in family therapy not only helped the social workers to engage in systemic practice (see Section 3.2.3), but also supplemented the formal training and coaching with their hands-on

teaching. As one of them concluded: “And I feel that [our clinician] has actually taught us to use those circular questions and to externalise [problems], and the dialogical [approach]… all those things, really hands-on teaching, and it has been, at least for me, extremely important”.

3.2.3 Participant responsiveness

3.2.3.1 Social workers

Participant responsiveness was categorised in two themes: positive and negative experiences. Overall, the social workers were very satisfied with the SPM, which evidently facilitated its implementation. Of all the citations related to participant responsiveness (N = 377), 71 per cent were positive.

Two elements in particular concerned positive experiences: the perceptions that SPM improved work-related wellbeing and practice, and that it provided a safe learning environment. For the most part, the interviewees’ perceptions of the model’s usefulness were connected to the clinician’s involvement in the team meetings. In applying systemic thinking and techniques during the meetings the clinician helped the social workers to consider the families’ situations from multiple perspectives and prevented them from making hasty decisions on the cases. The mutual reflection also eased the individual burden of responsibility and made it easier to plan interventions with the family. Some of the interviewees acknowledged that the model had not only enhanced their work-related well-being and sense of meaningfulness, but had also induced positive change among families, such as with case closure. Applying the techniques enabled them to evoke change in family members and help them “to take responsibility and come up with solutions” themselves, instead of the professionals making the decisions. The social workers also appreciated the coordinator’s help in taking minutes in the meetings, scheduling appointments and contacting other service providers, all of which helped them to improve their practice.

According to the interviews, the practitioners in two teams had formed a safe learning environment enhancing the uptake of systemic practice. All these team members shared high learning motivation and had clear roles. One of the teams had a well-established relationship with their clinician. The other team saw the clinician only in biweekly meetings but received practical support both from a practitioner trained in family therapy and from their skilful consultant social worker. These positive interrelationships and hands-on coaching in systemic practice (see Section 3.2.2) gave the social workers the confidence to discuss their feelings in the team meetings and to try out the techniques in practice. Their positive experiences of practice

enhanced their feelings of competence, which in turn strengthened their commitment to systemic practice.

The negative responses were associated with two elements: the low fidelity of the model and the impracticality of team meetings. Although the social workers were able to apply the systemic approach with a few families (see Section 3.1.3), they were still responsible for their whole caseload. The interviewees felt obliged to "prioritise" families involved in the intervention, which created a split sense of the reality: service as usual with some families and systemic practice with others. The "cheap version" of the model was a major concern. One team suggested that their motivation for SPM would be optimal if they implemented "the ideal model". Despite the challenges, however, the social workers seemed to appreciate the model in itself. Moreover, although most of them were satisfied with the team meetings, a few thought they were too long and unhelpful. This finding could be attributed to the large team size (as many as six SWs), which was detrimental to reflective discussion and lengthened the meetings. In sum, the social workers' perceptions on negative experiences and their linkage to motivation indicate that low fidelity might decrease participant responsiveness. The discrepancy concerning the team meetings could also reflect inadequate integration between the therapeutic approach and statutory social work.

A comparison of the qualitative results with our survey results revealed that 79 per cent of the survey respondents (n = 56) wished to continue using the model, and 76 per cent would recommend it to colleagues. As indicated in the interviews, the willingness to continue the implementation among all survey respondents was associated with their positive experiences of the weekly team meetings ($rs(51) = .78$, $p < .001$), and support from the clinician ($rs(51) = .63$, $p < .001$): yet, 44 per cent of them experienced the implementation as a burden. Nevertheless, half of these respondents wanted to continue using the model, which illustrates its high level of acceptability.

3.2.3.2 Families

Despite the limited evidence of systemic practice on the family level, most interviewees were satisfied with the help received from the child protective services. In a similar vein, a forthcoming pilot study reveals high service-related satisfaction among service-user respondents. However, there were no differences between the service-as-usual and the SPM groups, implying that the parents were equally satisfied in both. According to the interviewees, service users

whose social worker applied systemic techniques with them or had attended the reflective team meeting themselves felt that it gave them new perspectives on their situation. One father said that discussing family questions with several professionals in the meeting was, at its best, "empowering". However, five of the six users who knew that their case had been discussed in the team meeting were somewhat disappointed that the discussion had little impact on their family's service, indicating relatively weak linkage between the meetings and the practice. As one mother pointed out, "of course, the social workers can think about good practices or means to help a family, but I think that those means should be brought concretely to the family level".

3.2.4 Organisational factors

The following three themes were connected to organisational factors: caseloads, the leaders' commitment to change and staff turnover. Of all the citations related to organisational factors (N = 368), 91 per cent were coded as barriers. The social workers were able to discuss only a few of their cases in the team meetings, given their high caseloads, and consequently engaged in systemic practice mainly with these specific families (see Section 3.2.3). One interviewee who was dealing with 47 child protection cases said that her team frequently had to cancel meetings due to time pressure. There was too little time to meet the families and implement new techniques in any case, which in turn weakened the effect of the training: as one interviewee remarked, "I haven't had time even to try another kind of approach in my work".

According to our survey results, and contrary to the nationally recommended 20 cases per social worker, the average load increased from 32 to 35 cases in the course of the implementation. Surprisingly, the ANOVA results indicated that there were no significant differences among the fidelity groups regarding the number of cases discussed in a team meeting ($F(2, 53) = 0.61$, $p = .548$), the use of key techniques ($F(2, 53) = 0.46$, $p = .635$), or intensive casework ($F(2, 53) = 1.57$, $p = .218$). The Spearman correlation also gave interesting results indicating the lack of an association between caseloads and the willingness to continue with the SPM ($rs(51) = .25$, $p = .071$), and between caseloads and experienced burden ($rs(54) = -.26$, $p = .058$). However, as in the interviews, the survey data revealed a significant association between caseloads and the willingness to recommend SPM to colleagues ($rs(52) = .34$, $p = .012$). As anticipated, respondents with higher caseloads were less willing to recommend the model.

The interviewees were divided in their opinions about the commitment of agency leaders to the SPM. Those in site two in particular described their senior managers as supportive of their

work in that the agency had lessened their caseloads prior to the intervention. Interestingly, this team scored only four on a scale from zero to ten indicating that organisational support was not connected with fidelity to systemic practice in this context (see Table 7). Several social workers at other sites were disappointed in their agency leaders' lack of commitment, such as not arranging reasonable caseloads and poorly communicating team responsibilities. Consequently, some teams wondered whether the "disorganised" nature of the project was attributable to the lack of vision or implementation strategy. Although most agencies carried out structural changes, in some teams the contributions of the clinician and the consultant social worker were cut during the implementation, which frustrated the social workers. Another stress-inducing factor was that some agencies had initiated simultaneous non-intervention-related reforms such as moving into new offices. The imbalance between the SPM objectives and the circumstances caused further frustration. In comparison, only one in ten survey respondents thought that systemic thinking was embedded in their whole organisation.

Finally, although some teams experienced little or no staff turnover, others went through major changes during the implementation. At its most severe, teams were left with only a few members who had participated in the training. Given the high staff turnover and frequent sickness absences, a number of interviewees expressed the view that the original idea of small teams with a maximum of three social workers was not feasible. On the other hand, the low staff turnover in other teams helped to establish stable interrelationships and fostered mutual learning (see Section 3.2.3.1).

4 Discussion

The purpose of this study was to assess the fidelity of the SPM and to formulate hypotheses concerning the potential influencing factors based on our mixed-methods data. We observed considerable variability in the areas of fidelity measurement. Unexpectedly, there was also high variation between individual teams within the same sites. Whereas some adhered to systemic practice, others scarcely used such techniques, and even discontinued their implementation during the course of the study. We identified several implementation barriers: (1) a lack of clarity regarding systemic practice (*intervention complexity*), (2) insufficient training (*facilitation strategies*), and (3) high caseloads and staff turnover, and a lack of leader commitment to change (*organisational factors*). Regardless of these challenges, the social workers positively engaged

with the SPM (*participant responsiveness*). The teams that were more successful in adopting systemic practice enjoyed a positive learning environment (*participant responsiveness)* with little staff turnover (*organisational factors*) and received hands-on coaching from their team member who was specialised in systemic family therapy (*facilitation strategies*). It is interesting that although most teams reported several of the barriers listed above, they differed in their ability to engage in systemic practice. This finding underscores the significance of the facilitators.

Our results further support the association between different influencing factors (Carroll et al., 2007). For example, one hypothesis is that high motivation and a good team atmosphere could strengthen employee commitment to coaching, which in turn could be attributed to their skills and engagement with systemic practice. According to another hypothesis, against expectations, the level of fidelity might influence certain factors: low coverage could weaken participant motivation, for example, which in turn could hinder learning and systemic practice. These hypotheses should be refined in future research, and tested in different contexts.

We identified the following similarities between our findings and the results of previous research on the original UK model. First, Bostock et al. (2017) and Laird et al. (2018) report variation in delivering intended structural changes and conducting systemic practice, having also reported similar organisational barriers such as high caseloads. Moreover, Berrick et al. (2016) found that the caseloads of English social workers were half the size of those of their Finnish colleagues (i.e., 19-21 children per worker in England contrasted with 46-48 in Finland). To increase the coverage of systemic practice, in other words to allow time to reflect on cases and to interact with families, it is crucial to decrease the workload of those concerned in all kinds of settings. Second, we found that the clinician's role in maintaining systemic practice was crucial (Bostock et al. 2017; 2019).

We also found certain differences with regard to previous research. First, our findings were contradictory in relation to UK evaluations implying high levels of satisfaction with training (Bostock et al. 2017; Dugmore et al., 2018; Laird et al., 2018). The inconsistency could be attributable to the high number of local trainers who received the same ToT but differed in terms of experience and possibly also in training and practice skills. The UK agencies received training and coaching from a social enterprise, whose founders led the systemic change in Hackney (Bostock et al., 2017). This resource is not easily transferrable to other countries, and we discuss the implications in Section 4.1. The vague intervention description known to impede

implementation (Hasson, 2010) may also explain the lack of clarity concerning systemic practice in this study. Second, in contrast to findings in England (Bostock et al., 2017; Laird et al., 2018), the social workers in this study seldom discussed potential conflicts between the systemic approach and child risk management. This discrepancy could be attributed to the different orientations in the child protection systems in England and Finland: Finland has traditionally been characterised as family-service-oriented in contrast to the risk-oriented English system (Gilbert, 1997; Gilbert et al., 2011). Thus, it may be that a therapeutic orientation per se is more suited to the Finnish than to the English context. In fact, the foreign origin of the model came up in the discussions with social workers only a few times, which supports its transportability.

Finally, our results were mixed on the question of engaging the whole organisation, including senior leaders, in systemic change. On the one hand, the differing implementation outcomes, both highly positive and highly negative, within one site indicate that a reform of the whole system might not be a prerequisite for the implementation of the SPM, as implied in previous evaluations (Bostock et al., 2017; Laird et al., 2018; see also Sheehan et al., 2018). On the other hand, our findings indicate that leader support is essential in arranging the intended structural changes, providing the facilitation strategies and preventing staff turnover.

4.1 Implications for policy and practice

According to our findings, the SPM was widely accepted among social workers, but there were problems related to staff training and the transference of these ideas to social work practice, and it was difficult to create an organisational culture that would support systemic practice. Given that the model comprises multiple overlapping components and is demanding in terms of practical skills (see also Graig et al., 2013), to support its future implementation it would be useful to develop a manual based on the programme theory. This kind of guidance would also enhance the model's transportability. In particular, further attention should to be given to the roles of the consultant social worker and the coordinator, which have been found crucial for the maintenance of systemic practice in previous studies (Bostock et al., 2017; Forrester et al., 2013). Given that the training should give a clear and coherent picture of systemic practice that its users will understand, and equip them with necessary skills, future implementers should assess whether the ToT is the most effective solution. Furthermore, it is vital to maintain high-quality supervision to support systemic practice (Bostock et al., 2017, 2019). The need for

ongoing technical assistance has also been noted in other studies (Meyers et al., 2012; Sanclimenti et al., 2017).

The results of this study, although preliminary, have implications concerning implementing practice models across countries. We have shown that without adequate implementation support, practice models presumably fail to achieve the anticipated outcomes, or succeed to a limited extent. Given the complex nature of children's services as a change environment (Mildon et al., 2013), implementers should assess their readiness for change and, when necessary, enhance the organisational capacity (e.g., resources, infrastructure) before introducing an innovation. To ensure that this happens, those in charge of developing and disseminating practice models should list the resources that are generally required for their implementation. It is also necessary to formulate a comprehensive implementation strategy, including long-term maintenance support (Mildon & Shlonsky, 2011). These measures will also help to avoid unintentional harmful implementation effects such as practitioner frustration and opportunity costs. Finally, inherent in practice models is the potential for improving social work practice with a distinct and consistent approach, but endless adaptation and 'hybrid models' create challenges in terms of both implementation and evaluation (Baginsky et al., 2020). Various frameworks could be used to facilitate decision-making in adapting the models to any given setting (Stirman et al., 2013; Miller et al., 2020).

4.2 Limitations and future research

Two major limitations of this study are the use of self-reported fidelity data and the lack of a validated fidelity-measurement tool for the SPM. However, the findings give useful insights that could enhance the development of such a tool in the future. Although the two researchers had independent responsibilities in terms of gathering and analysing specific datasets, we worked to minimise a potential source of bias by regularly discussing data collection and interpretation throughout the study process. The small sample size limits the representativeness, however. In addition, the unequal distribution of respondent social workers in the fidelity categories made further statistical analysis, especially analyses of variance, difficult to interpret. Nevertheless, the mixed-methods design allowed us to conduct a comprehensive analysis of fidelity, the influencing factors and their interrelationship (see also Toomey et al., 2020). Specifically, the qualitative assessment of systemic practice produced a detailed picture of the team-level

differences. We have also demonstrated the need for future measurements of fidelity to focus not only on the agency level but also on the team and the individual levels. We acknowledge that observations of direct practice and team meetings would have enriched the interview and survey data in terms of assessing the fidelity of systemic practice. Finally, the study excluded the perspectives of leaders and trainers. We recommend further research with a stronger focus on organisational factors (including sufficient resourcing and the organisational culture) and the role of leaders, and on support for leaders in implementation efforts (see also Baginsky et al., 2020).

5 Conclusions

Changing practice in social care for children is challenging. Adding international transportability and the further adaptation of practice models to the implementation challenge considerably increases the complexity. Fidelity measurement helps to determine implementation outcomes, which are vital not only to leaders and practitioners but also to outcome evaluators. Furthermore, a better understanding of the barriers and facilitators will help policy makers and professionals in future implementation efforts in this field. In sum, we suggest that the RSW model could be adopted in new settings with adequate implementation support, but we also demonstrate the complexity of children's social care as a change environment.

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